U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 21Dec2001

CASE NO.:1998-BLA-1295

In the Matter of

NORA COLLINS, Survivor of JOHNNIE J. COLLINS,
Claimant

v.

POND CREEK MINING COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Leonard J. Stayton, Esquire,
For the Claimant

Ann B. Rembrant, Esquire,
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a survivor's claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.* [1] ("Act"), filed on September 29, 1997. (DX 1) [2]. The Act and implementing

[1] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The amended Part 718 regulations became effective on January 19, 2001 and were to apply to both pending and newly filed cases. The new Part 725 regulations also became effective on January 19, 2001. Some of the new procedural aspects of the Part 725 regulations, however, were to apply only to claims filed on or after January 19, 2001, *not* to

regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;

2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,

3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal workers pneumoconiosis" "CWP") as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

Johnnie J. Collins, the miner, filed two living miner's claims during his lifetime. The first claim was filed denied on June 4, 1981. (DX 32). The miner filed a second claim on June 5, 1983. On February 25, 1988, Administrative Law Judge, Leonard N. Lawrence issued a Decision and Order Awarding Benefits. (DX 32). On September 16, 1997, Mr. Collins died.

The claimant, Nora Collins, the surviving spouse of Johnnie J. Collins, filed a survivor's claim for black lung benefits on September 29, 1997. (DX 1). An initial finding of entitlement was made on

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pending cases. The Amendments to the Part 718 and 725 regulations were challenged in a lawsuit filed in the United States District Court for the District of Columbia in *National Mining Association v. Chao*, No. 1:00CV03086 (EGS). On February 9, 2001, the District Court issued a Preliminary Injunction Order which enjoined the application of the Amendments "except where the adjudicator, after briefing by the parties to the pending claim, determines that the regulations at issue in the instant lawsuit will not affect the outcome of the case." On February 14 , 2001, I issued a New Regulations Briefing Order, whereby I provided the parties an opportunity to address the application of the new amended regulatory provisions, but which also provided that a party's "*failure to submit a brief shall be construed as a position that the amended regulations will not affect the outcome of the claim*." (Emphasis in original). The parties filed briefs. The Employer contended that, in light of the uncertainty regarding the injunction, the hearing should be delayed. On the other hand, the Director stated that the new regulations will not have an effect upon the outcome of this claim. On July 16, 2001, I issued a Ruling and Order on Effect of New Regulations, in which I found that the application of the new regulations will not have an effect on the outcome of this case. On July 26, 2001, I issued an Errata to said Ruling and Order, confirming that the challenged regulations will not have an effect on the case. Accordingly, I ordered that the hearing would proceed as scheduled and provided the parties with a further opportunity to address the effect of the new regulations in their post-hearing briefs. On August 9, 2001, the United States District Court for the District of Columbia issued a decision granting the U.S. Department of Labor's motion for summary judgment in *National Mining Association v. Chao*, dissolved the Preliminary Injunction, and upheld the validity of the amended regulations.

[2] The following abbreviations are used for reference within this opinion: DX-Director's Exhibits; CX- Claimant's Exhibit; EX- Employer's Exhibit; TR- Hearing Transcript; Dep.- Deposition.

March 26, 1998. (DX 18). On April 15, 1998, the employer contested the determination. (DX 19). On July 24, 1998, the District Director, again, issued an initial finding of entitlement and ordered the employer to begin monthly payments of $455.40 in August 1998, with an additional lump sum due to the claimant in the amount of $5,007.80 for the period of September 1, 1997 to July 31, 1998. (DX 27). By letter dated July 30, 1998, employer contested its liability and requested that the claim be forward to the Office of Administrative Law Judges for a formal hearing. On September 8, 1998, the case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs (OWCP) for a formal hearing. (DX 33). The case was assigned to me on August 17, 2000.

On August 27, 2001, I held a hearing in Charleston, West Virginia, at which the claimant and employer were represented by counsel. No appearance was entered for the Director, OWCP. The parties were afforded the full opportunity to present evidence and argument. Claimant's exhibit ("CX") 1-30, Director's exhibits ("DX") 1-33 and Employer's exhibits ("EX")1-15 were admitted into the record.

ISSUES

I. Whether collateral estoppel precludes the employer from re-litigating whether the miner had coal workers' pneumoconiosis and whether the miner was totally disabled from pneumoconiosis?

II. Whether the miner had coal workers' pneumoconiosis?

III. Whether the miner's death was due to pneumoconiosis?

FINDINGS OF FACT

I. Background

A. Coal Miner

The parties agreed and I find the claimant's husband was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations, for at least 11 years. (TR 6). The parties agreed and I find the claimant is an eligible survivor of a miner. (TR 11).

B. Date of Filing

The claimant filed her claim for benefits, under the Act, on September 29, 1997. (DX 1). The matter was not contested and I find none of the Act's filing time limitations are applicable; thus, the claim was timely filed. (DX 1).

C. Responsible Operator

I find that Pond Creek Mining Company is the last employer for whom the miner worked a cumulative period of at least one year and the parties agreed it is the properly designated responsible coal mine operator in this case, under Subpart F, Part 25 of the Regulations. (DX 2, TR 12).

D. Personal and Employment History

The decedent miner was born on January 10, 1924. (DX 1). He married Nora Collins, the claimant, on June 2, 1987. (DX 1). Mr. Collins' last position in the coal mines was that of a deep mine extractor. (DX 1). He last worked in the coal mines in June of 1983 for Pond Creek Mining, Co. (DX 1, TR 12). During the year prior to his death, Mr. Collins was on an oxygen machine twenty four hours a day. (DX 1). Mr. Collins died on September 19, 1997, after suffering from cardiopulmonary arrest on September 7, 1999. (DX 12, 14).

Prior to his death, Mr. Collins' smoked one pack of cigarettes a day, but he quit around 1990. (DX 14).

II. Medical Evidence

I incorporate by reference the summary of evidence contained in Judge Lawrence's Decision and Order Awarding Living Miner Benefits, dated February 25, 1988. (DX 32). The following is a summary of the evidence submitted since the Decision and Order Awarding Benefits.

A. Chest X-rays

The radiographic evidence submitted in the record of this matter is contained in Appendix A, which is attached hereto.

In the present claim, twenty four readings of four X-rays taken between February 25, 1985 and September 10, 1997 were submitted. All of these readings were interpreted as negative for pneumoconiosis.

With respect to the radiographic evidence submitted in Mr. Collins' living miner's claim, I incorporate the summary of those X-ray readings contained in Judge Lawrence's Decision and Order, dated February 25, 1988.

B. Pulmonary Function Studies

Pulmonary Function Tests (PFS) are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV). I

incorporate the summary of pulmonary function studies contained in Judge Lawrence's Decision and Order, dated February 25, 1988.

C. Arterial Blood Gas Studies [3]

Blood gas studies are performed to detect an impairment in the process of aveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide in the blood indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled. I incorporate the summary of arterial blood gas studies contained in Judge Lawrence's Decision and Order, dated February 25, 1988.

D. Hospitalization Records

Included in the record are hospitalization records form Williamson Memorial Hospital. (DX 14). The records indicate that on September 7, 1997, Mr. Collins was admitted for cardiopulmonary arrest. The records note that Mr. Collins went into cardiac arrest in his home and was intubated and resuscitated and later transported by EMS to the hospital. Mr. Collins was admitted to the intensive care unit and found to have arrhythmia[4] overnight.

The records reflect Mr. Collins' past medical history and stated that Mr. Collins' has a history of cardiomyopathy, left ventricular systolic dysfunction, atrial arrhythmia and atrial flutter for which he had been on amiodarone therapy. Additionally, it was noted that Mr. Collins has a history of severe chronic obstructive pulmonary disease and coal workers' pneumoconiosis with chronic respiratory failure that has required frequent admissions to the hospital for acute exacerbation. Mr. Collins' history of coronary artery disease and left circumflex disease was noted. Furthermore, a cardiac workup was not recommended, given Mr. Collins' end stage lung condition.

In addition, Mr. Collins was admitted to Williamson Memorial Hospital on November 18, 1996. Mr. Collins was admitted for dyspnea. On admission, Mr. Collins was diagnosed with acute chronic respiratory failure and he was found to have cardiac arrhythmias and coronary artery disease.

Mr. Collins was also admitted to Williamson Memorial Hospital on October 14, 1996 with the chief complaint, again, being dyspnea. Mr. Collins' primary diagnoses were cardiac arrhythmia, coronary artery disease and chronic obstructive pulmonary disease. It was noted that Mr. Collins' was

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[3] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.
20 C.F.R. § 718.204(c) permits the use of such studies to establish "total disability." It provides:
In the absence of contrary probative evidence, evidence which meets the standards of either paragraphs (c)(1), (2), (3), (4), or (5) of this section shall establish a miner's total disability: . . .
(2) Arterial blood gas tests show the values listed in Appendix C to this part . . .

[4] Arrhythmia is the variation from the normal rhythm of the heart beat. *Dorland's Medical Dictionary,* Twenty Third Ed., (1982).

not a candidate for beta blocker therapy give the presence of severe chronic obstructive pulmonary disease.

E. Physicians' Reports

Included in the record is a physician report from Mann Younes, M.D., Mr. Collins' treating physician prior to his death. Dr. Younes is a B-reader and is board-certified in internal medicine and pulmonary diseases. In a letter dated November 10, 1997, Dr. Younes set forth his opinion regarding Mr. Collins' medical condition. (DX 13). Dr. Younes stated that Mr. Collins was his patient from October 20, 1994 to September of 1997. Dr. Younes noted that Mr. Collins' respiratory condition was very severe with frequent exacerbations and hospitalizations. Dr. Younes further noted that Mr. Collins' respiratory condition was so severe that in 1997 he required hospitalization once or twice a month. Dr. Younes further noted that Mr. Collins' last hospitalization was between September 6, 1997 and September 15, 1997, when he was brought to the hospital because he had respiratory arrest at home. Mr. Collins was put on the ventilator and after extubation developed hypoxic encephalopathy with delirium and restlessness. Dr. Younes added that on September 15, 1997, Mr. Collins was stable from a cardiac and respiratory standpoint and was discharged. However, Mr. Collins died the next day at home.

Dr. Younes concluded that Mr. Collins had severe respiratory disability from his coal workers' pneumoconiosis and that his severe pneumoconiosis was a major contributing factor to this death.

Additionally, the record includes a medical report from Dr. Younes' regarding his October 20, 1994 examination of Mr. Collins. Dr. Younes noted that Mr. Collins' complaints included dyspnea on exertion and shortness of breath. Dr. Younes' noted Mr. Collins extensive smoking history and forty two years of coal mine employment. Dr. Younes primary diagnoses included coal workers' pneumoconiosis, chronic obstructive pulmonary disease, hypertension, cardiac arrthymia. Dr. Younes reported that a chest X-ray performed on October 20, 1994 showed hyperinflation bi-basilar nodular infiltrates with a profusion of "2/1".

Dominic J. Gaziano, M.D., submitted a report dated January 1, 1998. (DX 15). Dr. Gaziano is a B-reader and is board-certified in internal medicine and pulmonary diseases. While Dr. Gaziano opined that Mr. Collins' death was not due to pneumoconiosis, Dr. Gaziano did find that pneumoconiosis was a substantially contributing factor to Mr. Collins' death. Dr. Gaziano added that Mr. Collins died as a result of cardio-pulmonary failure with a background of severe heart and lung disease.

At the request of counsel for employer, Gregory J. Fino, M.D., reviewed Mr. Collins' medical records. In a report dated September 16, 1998, Dr. Fino submitted his findings. (EX 1). Dr. Fino is a B-reader and is board certified in internal medicine and pulmonary diseases. Dr. Fino initially noted Mr. Collins' 29 years of coal mine employment.

Dr. Fino opined that Mr. Collins did not have a coal mine dust related pulmonary condition. Dr. Fino asserted that his opinion is supported by the fact that the majority of chest X-rays are negative for pneumoconiosis. Dr. Fino added that the spirometric evaluations showed an obstructive ventilitory abnormality based on the reduction in the FEV1/FVC ration, however, Dr. Fino maintained that these findings are not consistent with a coal dust related condition, but is rather consistent with cigarette smoking, pulmonary emphysema, non-occupational chronic bronchitis, and asthma. Dr. Fino explained that Mr. Collins' obstructive abnormality occurred in the absence of any interstitial abnormality. Accordingly, Dr. Fino opined that Mr. Collins' chronic obstructive pulmonary disease was secondary to smoking.

In addition, Dr. Fino noted that Mr. Collins' hospitalizations showed numerous admissions for respiratory failure, marked by episodes of severe hypoxia and hypercarbia. Dr. Fino added that, in order to have such severe hypoxia and hypercarbia secondary to coal mine dust inhalation, there must be significant pulmonary fibrosis. Dr. Fino noted that there is no significant evidence of pulmonary fibrosis. Moreover, Dr. Fino noted that all of the B readings were negative for pneumoconiosis, which Dr. Fino explains rules out a finding of pulmonary fibrosis.

Dr. Fino concluded that Mr. Collins' death was a result of his cardiac condition. Dr. Fino opined that Mr. Collins' had a significant history of coronary artery disease, noting that Mr. Collins had echocardiograms showing biventricular failure and significant arrhythmias, which were treated by anti-arrhythmic drugs. Accordingly, Dr. Fino found that Mr. Collins death was due to significant left ventricular disease, due to coronary artery disease.

Dr. Fino further concluded the Mr. Collins' coal dust inhalation did not play a role in his significant cardiac condition or his death. Dr. Fino explained that Mr. Collins' coronary artery disease was caused by atherosclerosis, which is the deposition of fat and cholesterol in the blood vessels which causes blocked blood vessels. Dr. Fino followed by noting that atherosclerosis is a disease of the general population and Dr. Fino cited to numerous medical studies to support this assertion.

Dr. Fino submitted a supplemental report, dated August 5, 1999. (EX 10). Despite his review of additional medical evidence, Dr. Fino's opinion did not change. Dr. Fino again concluded that Mr. Collins' death was due to cardiac disease unrelated to the inhalation of coal mine dust.

Additionally, Dr. Fino was deposed on February 3, 2000. (EX 14). During his deposition, Dr. Fino reiterated the findings set forth in his earlier reports. Dr. Fino discredited the findings of Dr. Younes, Mr. Collins' treating physician. Specifically, Dr. Fino disagreed with Dr. Younes conclusion that Mr.Collins' severe coal workers' pneumoconiosis was a contributing factor to his death. (EX 14, pg. 22). Dr. Fino opined that Mr. Collins' died of a sudden cardiac death. *Id.* Dr. Fino added that Dr. Younes' opinion has no basis and just because Mr. Collins' had bad lung disease, irrespective of its cause, that it was not a contributing cause to his death. (EX 14, pg. 24).

Thomas M. Jarboe, M.D., reviewed Mr. Collins medical records. Dr. Jarboe is a B-reader is board-certified in internal medicine and pulmonary diseases. In a report dated October 9, 1998, Dr. Jarboe submitted his findings. (EX 2).

Dr. Jarboe noted that Mr. Collins' pulmonary status continued to deteriorate long after he left the coal mines, to the point he suffered respiratory failure. Dr. Jarboe additionally noted the Mr. Collins continued to smoke heavily until 1990 or 1991. Dr. Jarboe opined that there was insufficient medical evidence of record to establish coal workers' pneumoconiosis. Dr. Jarboe added that the majority of the X-ray readings by B readers were negative for pneumoconiosis.

Dr. Jarboe opined that Mr. Collins suffered from a severe respiratory impairment, however, he attributed his impairment to cigarette smoking, not coal dust inhalation. Dr. Jarboe added that, in his opinion, dust inhalation in the absence of progressive massive fibrosis, does not cause this degree of pulmonary impairment. Dr. Jarboe added that his primary problems were those of his severe obstructive lung disease and chronic respiratory failure and severe cardiac disease manifested by markedly compromised left ventricular function, which Dr. Jarboe attributed to Mr. Collins' smoking history.

Dr. Jarboe concluded that coal workers' pneumoconiosis or coal mine dust exposure did not play any role in hastening Mr. Collins' death. Dr. Jarboe opined that Mr. Collins' death was due to a combination of severe respiratory insufficiency due to chronic obstructive pulmonary disease. Dr. Jarboe added that he felt that his COPD was caused by a long history of cigarette smoking. Additionally, Dr. Jarboe attributed his death to his coronary artery disease and severe left ventricular dysfunction. Dr. Jarboe further stated that it is likely that some type of cardiac event was the cause of his sudden death at home. On a final note, Dr. Jarboe stated that his opinion would not change if Mr. Collins' was found to have coal workers' pneumoconiosis.

James R. Castle, M.D., reviewed Mr. Collins' medical records, including medical histories, physical examinations, radiographic evaluations, physiologic testing and arterial blood gas tests. In a report dated November 9, 1998, Dr. Castle submitted his findings. (EX 6). Dr. Castle is a B-reader and is board-certified in internal medicine and pulmonary diseases.

Dr. Castle noted that Mr.Collins worked at least forty years in and around coal mines. Dr. Castle also noted Mr. Collins forty pack a year smoking habit. Moreover, Dr. Castle noted Mr. Collins' history of coronary artery disease.

Dr. Castle opined that Mr. Collins did not suffer from coal workers' pneumoconiosis, despite his forty year history of coal mine employment. Dr. Castle noted that there was insufficient medical evidence of record to establish coal workers' pneumoconiosis. Specifically, Dr. Castle noted that the majority of B-readers found no evidence of pneumoconiosis.

Dr. Castle concluded that Mr. Collins' death was not caused by coal workers' pneumoconiosis. While he noted several episodes where Mr. Collins was noted to have the presence

of crackles or crepitations in the lower lung bases, Dr. Castle noted that these occurrences were all at times when he was admitted to the hospital with cardiac abnormalities and respiratory symptoms. Dr. Castle added that these findings are not specific for any one disease process, but may occur most commonly in those individuals suffering from congestive heart failure and left ventricular dysfunction .

Dr. Castle opined that Mr. Collins arterial blood gas studies showed evidence of severe hypoxemia associated with severe hypercarbia. Dr. Castled added that these are not the findings of hypoxemia associated with coal workers' pneumoconiosis. Dr. Castle explained that Mr. Collins' elevated pCO2 evidenced tobacco smoke induced chronic obstructive pulmonary disease. Moreover, Dr. Castle stated that this condition was further aggravated by his underlying cardiomyopathy and severe congestive heart failure. Dr. Castle further stated that individuals who have severe heart failure may have hypercarbia and elevation of pCO2 even in the absence of underlying lung disease. Accordingly, Dr. Castle concluded that Mr. Collins had a combination of severe congestive heart failure, cardiomyopathy, and tobacco smoke induced chronic obstructive pulmonary disease which resulted in not only his physiologic findings, including blood gas findings, but ultimately in his demise.

In addition, Dr. Castle opined that Mr. Collins' death was a cardiac event due to an arrhythmia. Dr. Castle added that Mr. Collins' death was not due to an exacerbation of a respiratory failure or an exacerbation of any underlying lung disease. Dr. Castle concluded that Mr. Collins' death was due to his cardiac disease (coronary artery disease, congestive heart failure, ischemic cardiomyopathy, and multiple arrhythmias including heart block) and his tobacco smoke induced chronic obstructive pulmonary disease.

On March 8, 1999, Dr. Castle was deposed. (EX 8). During his deposition, Dr. Castle reiterated the findings set forth in his earlier report. In addition, Dr. Castle stated that it was clear to him that what Dr. Younes described was a cardiac death due to a cardiac arrhythmia and not a respiratory death. (EX 8, pg. 25). Dr. Castle added that there is nothing about this man's demise that would indicate that he had a respiratory cause of death. *Id.* With respect to the evidence of record noting that Mr. Collins had a history of cor pulmonale, Dr. Castle stated that when cor pulmonale exists, we expect to see hypertrophy or thickening of the right ventricle and he stated that he did not see that in this case, to confirm the diagnosis of cor pulmonale. (EX 8, pg. 26).

William Keith Campbell Morgan, M.D., reviewed Mr. Collins' medical records. Dr. Morgan submitted his findings in a report dated January 26, 1999. (EX 7). Dr. Morgan is a B-reader. Dr. Morgan opined that Mr. Collins suffered from significant obstructive pulmonary impairment due to his long smoking history. Additionally, Dr. Morgan asserted that there was insufficient evidence of record to establish coal workers' pneumoconiosis, noting that he interpreted Mr. Collins' X-rays, dated February 27, 1985 and September 7, 1997, as completely negative for pneumoconiosis.

Dr. Morgan further opined that Mr. Collins' death was the consequence of an arrhythmia. Dr. Morgan noted that Mr. Collins had been admitted to the hospital several times on account of atrial fibrillation and atrial flutter, where he was treated with anti-arrhythmic drugs. Dr. Morgan added that Mr. Collins was shown to have echocardigraphic evidence of coronary artery disease, despite Dr.

Younes pronoucement that Mr. Collins cardiac catheterization had not shown any coronary disease. Dr. Morgan further discredited Dr. Younes, by stating that Mr. Collins' final admission and subsequent events are not compatible with his dying from respiratory failure, as reported by Dr. Younes. Dr. Morgan explained that respiratory failure comes gradually and slowly gets worse and Mr. Collins died suddenly at home.

Dr. Morgan further opined that Mr. Collins suffered from severe hypoxemia, which he noted makes one more prone to develop arrhythmias and further, it makes the arrhythmias more difficult to treat. However, Dr. Morgan followed by noting that Mr. Collins' hypoxemia was not related to his coal mine dust exposure.

At the request of counsel for employer, George L. Zaldivar, M.D., was deposed on March 17, 1999. (EX 9). Dr. Zaldivar is a B-reader and is board certified in internal medicine and pulmonary diseases. Dr. Zaldivar stated that he examined Mr. Collins in 1985, in connection with his living miner's claim. Additionally, on July 24, 1997, Dr. Zaldivar provided a consulting opinion regarding sleep apnea to Mr. Collins' treating pulmonologist. (EX 9, pg. 13).

Dr. Zaldivar noted that in 1985 he found no evidence that Mr. Collins suffered from pneumoconiosis. (EX 9, pg. 19). Dr. Zaldivar noted that Mr. Collins most recent X-ray readings were also negative for pneumoconiosis. (EX 9, pg. 38). Dr. Zaldivar added that the cause for Mr. Collins' pulmonary hypertension was the failure of the left ventricle, not due to cor pulmonale caused by pulmonary disease, but rather to pressure of the blood backing up into the pulmonary system, because the left ventricle was failing. *Id.*

Dr. Zaldivar further opined that Mr. Collins' death was not hastened by coal workers' pneumoconiosis for two reasons: 1) he found no evidence of coal workers' pneumoconiosis; and 2) Mr. Collins' death was caused by cardiac arrest, which was unrelated to his lungs. (EX 9, pg. 42-43). Dr. Zaldivar further explained that cause of death was really cardiac arrest, which in light of the severe cardiac dysfunction and cardiac arrhythmias unrelated to his lungs, it is reasonable to record that the problem was cardiac death in spite of fact that there was severe lung disease present. (EX 9, 42-43). Moreover, Dr. Zaldivar maintained that it is possible for an individual to have coal workers' pneumoconiosis and pneumoconiosis contributing to pulmonary impairment without that individual's death ultimately being due to pneumoconiosis. (EX 9, pg. 48). Dr. Zaldivar added that it view of the records, "it appears" that the heart would have done what it did regardless of the state of the lungs. (EX 9, pg. 43). Dr. Zaldivar further stated that Mr. Collins died a cardiac death irregardless of any pulmonary complications, noting that Mr. Collins was known to have severe cardiac disease, severe cardiac malfunction and ischemic heart disease and previous heart attacks. (EX 9, pg. 49).

In addition, Dr. Zaldivar noted that he did not find any evidence of cor pulmonale in Mr. Collins' medical records. (EX 9, pg. 50). Dr. Zaldivar explained that in order to diagnose cor pulmonale one needs to find a healthy heart, which was not present. *Id.*

Abdul Kader Dahhan, M.D., reviewed Mr. Collins' medical records and submitted a report dated, August 10, 1999. (EX 10). Dr. Dahhan is a B-reader and is board-certified in internal medicine and pulmonary diseases.

Based upon his review of Mr. Collins' medical records Dr. Dahhan opined that Mr. Collins' death was cardiac in origin due to his severe coronary artery disease that precipitated various cardiac arrhythmia that was refractory to various therapies. Accordingly, Dr. Dahhan concluded that Mr.Collins' death was not caused or hastened by his coal dust exposure or the possibility of coal workers' pneumoconiosis.

While Dr. Dahhan maintained that Mr. Collins suffered from a obstructive ventilatory impairment, Dr. Dahhan asserted that it was not the result of his coal mine dust exposure, but rather the result of his smoking history. Dr. Dahhan noted that Mr. Collins' obstructive airway disease was being treated by his family physician with multiple bronchodilators including oral and inhalation routes, indicating that his physician felt that he was responsive to such therapy. Dr. Dahhan noted that this finding is inconsistent with the permanent adverse affects of coal dust on the respiratory system.

Dr. Dahhan noted that Mr. Collins' suffered from hardening of the arteries of the coronary circulation, a disease of the general public at large, which is not caused by the inhalation of coal dust or coal workers' pneumoconiosis. Dr. Dahhan added that since Mr. Collins' death was related to a disease of the general public at large, Dr. Dahhan concluded that his death would have occurred at the same time and in the same manner regardless of whether or not he had ever worked in the coal mine industry.

Additionally, Samuel V. Spagnolo reviewed Mr. Collins' medical records and submitted a report dated November 19, 1999. (EX 11). Dr. Spagnolo is board-certified in internal medicine and pulmonary diseases.

Dr. Spagnolo opined that there was insufficient medical evidence establishing that Mr. Collins had coal workers' pneumoconiosis, citing to the chest X-rays readings made by Drs.Wiot, Shipley, Wheeler, Scott, Spitz and Kim.

Dr. Spagnolo further noted that Mr. Collins' respiratory impairment was most consistent with his history of cigarette smoking. Dr. Spagnolo further noted that Mr. Collins' worsening airflow obstruction, as evidenced by his elevated PaCO2, may be explained by Mr. Collins' excessive weight (220 lb.). Additionally, Dr. Spagnolo opined that Mr. Collins' sleep apnea can explain his elevated PaCO2. Moreover, Dr. Spagnolo asserted that following his myocardial infarction Mr. Collins' underlying severe left heart dysfunction and congestive heart failure certainly contributed to the further lowering of the arterial oxygen tension, thus Mr. Collins' hypoxemia and hypercapnia are easily explained and these abnormalities were not caused by pneumoconiosis.

Dr. Spagnolo further opined that prior to the development of his myocardial infarction and left ventricular dysfunction, Mr. Collins would have had adequate capacity to perform his coal mine

employment. Dr. Spagnolo added that subsequently Mr. Collins congestive heart failure and general medical condition resulted in a reduced capacity to perform physical activity. Dr. Spagnolo concluded that Mr. Collins' death was unrelated to and not hastened, even briefly, by pneumoconiosis nor was pneumoconiosis a contributing factor in his death.

IV. Death Certificate

The death certificate, signed by Dr. Younes, lists the date of death as September 16, 1997. (DX 12). The cause of death was listed as cardiac arrest due to respiratory failure. Additionally, coal workers' pneumoconiosis was listed as a significant condition contributing to death. No autopsy was performed.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

Part 718 applies to survivors' claims which are filed on or after April 1, 1980. 20 C.F.R. § 718.1. There are four possible methods of analyzing evidence in a survivor's claim under Part 718: (1) where the survivor's claim is filed prior to January 1, 1982 and the miner is entitled to benefits as the result of a living miner's claim filed prior to January 1, 1982; (2) the survivor's claim is filed prior to January 1, 1982 and there is no living miner's claim or the miner is not found entitled to benefits as the result of a living miner's claim filed prior to January 1, 1982; (3) the survivor's claim is filed after January 1, 1982 and the miner was found entitled to benefits as the result of a living miner's claim filed prior to January 1, 1982; and (4) the survivor's claim is filed after January 1, 1982 where there is no living miner's claim filed prior to January 1, 1982 or the miner is found not entitled to benefits as a result of a living miner's claim filed prior to January 1, 1982. The fourth, Subsection 718.205(c) applies to this claim.[5]

The Part 718 regulations provide that a survivor is entitled to benefits only where the miner *died due to pneumoconiosis.* 20 C.F.R. § 718.205(a). As a result, the survivor of a miner who was totally disabled due to pneumoconiosis at the time of death, but died due to an unrelated cause, is not entitled to benefits. 20 C.F.R. § 718.205(c). Under § 718.205(c)(4), if the principal cause of death is a medical condition unrelated to pneumoconiosis, the survivor is not entitled to benefits unless the evidence establishes that pneumoconiosis was a substantially contributing cause of the death.

The Board has held that in a Part 718 survivor's claim, the Judge must make a threshold determination as to the existence of pneumoconiosis under 20 C.F.R. § 718.202(a) prior to considering

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[5] The survivor is not entitled to the use of lay evidence, or the presumptions at §§ 718.303 and 718.305 to aid in establishing entitlement to survivors' benefits. A survivor is automatically entitled to benefits only where the miner was found entitled to benefits as a result of a claim filed prior to January 1, 1982. However, a survivor is not automatically entitled to such benefits under a claim filed on or after January 1, 1982 where the miner is not entitled to benefits as a result of the miner's claim filed prior to January 1, 1982 or where no miner's claim was filed prior to January 1, 1982. *Neeley v. Director, OWCP*, 11 B.L.R. 1-85 (1988).

whether the miner's death was due to the disease under § 718.205. *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993).

B. Collateral Estoppel

As stated earlier, on February 25, 1988, Administrative Law Judge, Leonard N. Lawrence issued a Decision and Order Awarding Benefits to the decedent-miner. (DX 32). Counsel for employer contends that collateral estoppel does not preclude the parties from relitigating whether the decedent-miner had pneumoconiosis and whether his pneumoconiosis was the result of his coal mine employment. [6] Specifically, employer asserts that the doctrine is not applicable in the instant matter, because the claimants are different and the criteria for adjudicating a miner's claim for benefits is different from that utilized for adjudicating a survivor's claim for benefits.

Collateral estoppel forecloses the relitigation of issues of fact or law that are identical to he issues which have already been determined and necessarily decided in prior litigation in which the party against whom [issue preclusion] is asserted had a full and fair opportunity to litigate. *Hughes v. Clinchfield Coal Co.*, 21 B.L.R. 1-134, 1-137 (1999) (en banc), citing *Ramsey v. INS*, 14 F.3d 206 (4th Cir. 1994). To successfully invoke the doctrine of collateral estoppel, the party asserting it must establish the following criteria:

1. the precise issue raised in the present case must have been raised and actually litigated in the prior proceeding;

2. determination of the issue must have been necessary to the outcome of the prior determination;

3. the prior proceeding must have resulted in a final judgment on the merits; and

4. the party against whom estoppel is sought must have had a full and fair opportunity to litigate the issue in the prior proceeding.

Villian v. Ziegler Coal Company, BRB NO. 00-0451 BLA, (2001); *Freeman v. United Coal Mining Co. v. Director OWCP*, 20 F.3d 289, 18 B.L.R. 2-189 (7th Cir. 1994).

It is generally held that the doctrine of collateral estoppel is applicable in survivor's claims where there was a prior decision and order awarding benefits in the living miner's claims. *See Villain v. Ziegler Coal Company*, BRB No. 00-0451 (January 29, 2001, unpublished). In *Ziegler*, the Board reasoned that:

[6] Additionally, counsel for employer initially argued that collateral estoppel does not bar consideration of the length of the decedent-miner's coal mine employment and responsible operator issues. However, at the hearing counsel for employer stipulated to eleven years of coal mine employment and withdrew its objection to the responsible operator issue.

> [f]irst, the existence of pneumoconiosis was raised in the present survivor's claim and actually litigated in the prior proceeding on the miner's claim. Second, the determination of the existence of pneumoconiosis was necessary to the previous miner's award of benefits, unlike a denial of benefits, inasmuch as the presence of pneumoconiosis pursuant to Section 718.202(a) is a requisite element of entitlement to benefits in a part 718 case. *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); *Perry v. Director , OWCP*, 9 B.L.R. 1-1 (1986)(*en banc*). Third, the prior proceeding resulted in a final judgment on the merits inasmuch as the Board affirmed Administrative Law Judge Mill's miner's claim was in payment status until his demise. Finally, employer had a full and fair opportunity to litigate this issue in the prior miner's claim.

Accordingly, the Board concluded that the application of the doctrine of collateral estoppel was appropriate in the survivor's claim, and therefore, the employer was precluded from relitigating whether the miner had pneumoconiosis.[7]

However, more recently, in *Dorothy M. Howard v. Valley Camp Coal Company*, BRB No. 00-1034 (August 22, 2001, unpublished), the Benefits Review Board held that collateral estoppel was not applicable in a survivor's claim, despite the fact that the decedent-miner was previously awarded living miner's benefits. In *Howard*, the Board noted that when the miner's claim was adjudicated the employer did not contest the fact that the miner suffered from pneumoconiosis, the employer maintained that there was sufficient evidence to establish pneumoconiosis under one of the four methods set out at 20 C.F.R. § 718.202(a)(1)-(4). However, the Board added that subsequent to the issuance of the award of benefits in the miner's claim, the Fourth Circuit held that although Section 718.202(a) enumerates four distinct methods of establishing pneumoconiosis, all types of relevant evidence must be weighed together to determine whether a miner suffers from the disease. *Island Creek Coal Company v. Compton*, 211 F.3d 203, B.L.R. (4th Circuit, 2000); see also *Penn Allegheny Coal Co. v. Williams* 114 F.3d 33, 21 B.L.R. 2-104 (3rd Circuit, 1997). Accordingly, the Board held that in light of the change of law enunciated in *Compton*, the issue of whether the existence of pneumoconiosis has been established pursuant to Section 718.202(a), is not identical to the one previously litigated and actually determined in the miner's claim, and therefore, collateral estoppel does not apply. *Id.*

The present claim is factually similar to *Howard*. Mr. Collins' was awarded benefits on February 25, 1998, which was before *Compton* was decided. In accordance with *Howard*, I find that collateral estoppel does not preclude the employer from relitigating whether the decedent-miner had coal workers' pneumoconiosis and whether his pneumoconiosis was the result of his coal mine employment, as the issues are not identical.[8] Accordingly, I am bound to apply *Compton* in

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[7] In *Ziegler* the Board noted that autopsy exception announced in *Hughes v. Clinchfield Coal Co.*, 21 B.L.R. 1-134 (1999)(en banc), was not applicable. In *Hughes*, the Board held that where a survivor's claim includes autopsy evidence which was not available and could not have been adduced at the time of adjudication of the miner's claim, an exception to the application of collateral estoppel may be warranted to allow relitigation of the issue of occupational pneumoconiosis.

[8] I recognize that the employer in the instant case did contest whether the decedent-miner had pneumoconiosis in the living miner's claim, as distinguished from *Howard*, however, this distinction is insignificant. Even though the employer

conjunction with Section 718.202(a) in determining whether the decedent-miner had coal workers' pneumoconiosis.

C. Existence of Pneumoconiosis

30 U.S.C. § 902(b) and 20 C.F.R. § 718.201 define pneumoconiosis as a "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." [9] The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis.[10] 20 C.F.R. § 718.201. The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."

" . . . [T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing*, *Rose v. Clinchfield Coal Co.*, 614 F. 2d 936, 938 (4th Cir. 1980). Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*,

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contested the issue of pneumoconiosis, at the time of the living miner's claim *Compton* was not decided, and therefore, the Administrative Law Judge was not instructed that all types of relevant evidence must be weighed together to determine whether a miner suffers from pneumoconiosis. Accordingly, I find that *Compton* must now be applied in determining whether the decedent-miner had coal workers' pneumoconiosis.

[9] Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1364; *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3d Cir. 1995) at 314-315.

[10] Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

(Emphasis added).

3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995).

The Board has recently adopted the Director's position to hold that "a transient aggravation of a non-occupational pulmonary condition is insufficient to establish pneumoconiosis as defined at Section 718.201." *Henley v. Conan and Co.*, 21 B.L.R. 1-148, BRB No. 98-1114 BLA (May 11, 1999).[11]

The claimant has the burden of proving the existence of pneumoconiosis by any one of four methods. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrefutable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.[12] 20 C.F.R. § 718.202(a). Pulmonary function studies are not diagnostic of the presence or absence of pneumoconiosis. *Burke v. Director, OWCP*, 3 B.L.R. 1-410 (1981).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis. This is contrary to the Board's view that an administrative law judge may weigh the evidence under each subsection separately, *i.e.* x-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the court cited to the Third Circuit's decision in *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 24-25 (3d Cir. 1997) which requires the same analysis.

The claimant has not established pneumoconiosis pursuant to subsection 718.202(a)(2) by autopsy or biopsy evidence. The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that sections presumptions are applicable. There is no evidence of complicated pneumoconiosis in this case.

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[11] As a result, the Board concluded that the ALJ erred in finding legal pneumoconiosis based upon medical opinions which diagnosed a temporary worsening of pulmonary symptoms due to exposure to coal dust, but no permanent effect. Id.

[12] In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel*, 21 B.L.R. 1-182 (1999) *citing Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are "documented" (medical), i.e., the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

A finding of the existence of pneumoconiosis may be made with positive chest x-ray evidence.[13] 20 C.F.R. § 718.202(a)(1). The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category 0, including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). "[W]here two or more x-ray reports are in conflict, in evaluating such x-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such x-rays." *Id.; Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985)."(Emphasis added). (Fact one is board-certified in internal medicine or highly published is not so equated). *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991) at 1-37. Readers who are Board-Certified Radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n. 5 (1985).

While a judge is not required to defer to the numerical superiority of x-ray evidence, although it is within his or her discretion to do so. *Wilt v. Woverine Mining Co.*, 14 B.L.R. 1-70 (1990) citing *Edmiston v. F & R Coal*, 14 B.L.R. 1-65 (1990). The ALJ must rely on the evidence which he deems to be most probative, even where it is contrary to the numerical majority. *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1984).

In addition, the Fourth Circuit holds that a judge may afford more weight to recent medical evidence. *Adkins v. Director, OWCP*, 958 F.2d 49, 16 B.L.R. 2-61 (4th Cir. 1992). It is rational to credit more recent evidence, solely on the basis of recency, only if it shows the miner's condition has progressed or worsened. The court reasoned that, because it is impossible to reconcile conflicting evidence based on its chronological order if the evidence shows that a miner's condition has <u>improved</u>, inasmuch as pneumoconiosis is a progressive disease and claimants cannot get better, "[e]ither the earlier or the later result must be wrong, and it is just as likely that the later evidence is faulty as the as the earlier. . ." *See also, Thorn v. Itmann Coal Co.*, 3 F.3d 713, 18 B.L.R. 2-16 (4th Cir. 1993).

In the present claim, twenty four readings of four X-rays taken between February 25, 1985 and September 10, 1997 were submitted. While employer has submitted six readings of the February 27,

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[13] "There are twelve levels of profusion classification for the radiographic interpretation of simple pneumoconiosis. 2/3 is the fourth highest profusion and 3/2 the third. *See* N. LeRoy Lapp, "A Lawyer's Medical Guide to Black Lung Litigation," 83 *W. Va. Law Review* 721, 729-731 (1981)." Cited in *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1359, n. 1.

1985 X-ray, I am not considering these X-ray readings, as I find that employer had an opportunity to submit these readings in the living miner's claim.[14] However, I am considering the more recent X-rays from 1997, as they were not in the record in the living miner's claim and they are highly probative.

Of the twenty four X-ray readings submitted in the present claim, all of the readings were interpreted as negative for pneumoconiosis. I further note that all of the reviewing physicians were either B-readers or dually-qualified physicians. While I recognize that there were positive X-ray readings submitted in Mr.Collins' living miner's claim, I give more weight to the recent X-ray evidence, since these X-rays are more probative of Mr.Collins' condition prior to his death. Furthermore, I note that the X-ray evidence submitted in Mr. Collins' living miner's claim was found to be insufficient, in and of themselves, to establish pneumoconiosis by Judge Lawrence. Accordingly, I find that the radiographic evidence of record is insufficient to establish that the decedent-miner had coal workers' pneumoconiosis.

Additionally, a determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data and medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative x-ray. 20 C.F.R. § 718.202(a). Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contraindicates it. *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

In the present claim, nine physician reports were submitted. [15] Of the nine physicians only Dr. Gaziano and Dr. Younes opined that Mr. Collins suffered from pneumoconiosis and that pneumoconiosis substantially contributed to his death. Despite the opinions of Drs. Gaziano and Younes, I find that the evidence of record fails to establish, by a preponderance of the evidence, that Mr. Collins had pneumoconiosis.

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[14] While I have found that collateral estoppel does not apply in the instant matter, I do not believe that this gives the employer the opportunity to submit additional readings of X-rays that were of record in the living miner's claim, as I believe that this gives the employer a "windfall", which is inconsistent with the holding in *Hughes*. I further note that even if I considered the X-ray readings, dated February 27, 1985, they would not change the outcome of my decision, as I find them far less probative than the more recent radiographic evidence of record.

[15] While I have considered the physician reports submitted by Dr. Rasmussen and Dr. Zaldivar in Mr. Collins prior claim, I have given more weight to the more recent physician reports submitted in the present claim.

While Dr. Gaziano asserted that Mr. Collins had coal workers' pneumoconiosis, Dr. Gaziano failed to provide any explanation for his diagnosis, except that Mr. Collins previously received black lung benefits. Accordingly, I do not find Dr. Gaziano's opinion well documented or well reasoned.

Dr. Younes, Mr. Collins' treating physician, maintained that Mr. Collins had coal workers' pneumoconiosis. Dr. Younes based his finding on his three year treatment of Mr. Collins for his respiratory problems. Dr. Younes diagnosed Mr. Collins with coal workers' pneumoconiosis and interpreted Mr. Collins' chest X-ray, dated October 24, 1994, as positive for pneumoconiosis with an ILO classification of a 2/1. Additionally, Dr. Younes diagnosed Mr. Collins with chronic obstructive pulmonary disease. While Dr. Younes noted Mr. Collins extensive smoking history, Dr. Younes did not address to what extent Mr. Collins' smoking history contributed to his chronic obstructive pulmonary disease. Although Dr. Younes was Mr. Collins' treating physician from October 20, 1994 to September of 1997, his findings have been contradicted by seven qualified physicians of record. Moreover, while Dr. Younes interpreted Mr. Collins' October 24, 1994 X-ray as positive for pneumoconiosis, the more recent X-ray evidence of record, including three X-rays taken shortly before Mr. Collins' death, were unanimously interpreted as negative for pneumoconiosis by qualified physicians. Additionally, seven other qualified physicians of record maintained that Mr. Collins' chronic obstructive pulmonary disease was the result of his extensive smoking history and not the result of his coal mine employment. Furthermore, claimant's counsel failed to provide a description of the frequency and extent of the treatment provided by Dr. Younes, in order to find Dr. Younes opinion more credible. Accordingly, for the reasons set forth above, I find Dr. Younes opinion less probative, and therefore, I give it little weight in comparison to the contradictory evidence of record.

While it is generally held that more weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically, 20 C.F.R. §§ 718.104(d) [16], *See Also*, *Onderko v. Director, OWCP*, 14

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[16] At 20 C.F.R. §§ 718.104(d) (Dec. 20, 2000), the amended regulations require that a treating physician's opinion be considered and state the following:

> (d) Treating physician. In weighing the medical evidence of record relevant to whether the miner suffers, or suffered, from pneumoconiosis, whether the pneumoconiosis arose out of coal mine employment, and whether the miner is, or was, totally disabled by pneumoconiosis or died due to pneumoconiosis, the adjudication officer must give consideration to the relationship between the miner and any treating physician whose report is admitted into the record. Specifically, the adjudication officer shall take into consideration the following factors in weighing the opinion of the miner's treating physician:
>
> (1) Nature of relationship. The opinion of a physician who has treated the miner for respiratory or pulmonary conditions is entitled to more weight than a physician who has treated the miner for non-respiratory conditions;
> (2) Duration of relationship. The length of the treatment relationship demonstrates whether the physician has observed the miner long enough to obtain a superior understanding of his or her condition;
> (3) Frequency of treatment. The frequency of physician-patient visits demonstrates whether the physician has observed the miner often enough to obtain a superior understanding of his or her condition;
> (4) Extent of treatment. The types of testing and examinations conducted during the treatment relationship demonstrate whether the physician has obtained superior and relevant information concerning the miner's condition;

B.L.R. 1-2 (1989), in *Collins v. J & L Steel (LTV Steel)*, 21 B.L.R. 1-182 (1999), the Board held that it was error for the administrative law judge to give greater weight to a treating physician's opinion without addressing its "flaws," *i.e.*, whether the doctor's failure to discuss the miner's lung cancer and heavy smoking history rendered his report less probative.

An administrative law judge "is not required to accord greater weight to the opinion of a physician based solely on his status as claimant's treating physician. Rather, this is one factor which may be taken into consideration . . ." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994). Other factors to be considered include whether the report is well-reasoned and well-documented. *McClendon v. Drummond Coal Co.*, 12 B.L.R. 2- 108 (11th Cir. 1988) (a well-reasoned, well-documented treating physician's report may be given greater weight); *Amax Coal Co. v. Franklin*, 957 F.2d 355 (7th Cir. 1992) (a treating physician's report which is not well-reasoned or well-documented should not be given greater weight); *Amax Coal Co. v. Beasley*, 957 F.2d 324 (7th Cir. 1992). Similarly, in *Lango v. Director, OWCP*, 104 F.3d 573 (3d Cir. 1997), the court held that a treating physician's opinion may be accorded greater weight than the opinions of other physicians of record but "the ALJ may permissibly require the treating physician to provide more than a conclusory statement before finding that pneumoconiosis contributed to the miner's death."

Despite the findings of Drs. Gaziano and Younes, Drs. Fino, Jarboe, Castle, Morgan, Zaldivar, Dahhan and Spagnolo all concluded that Mr. Collins did not have coal workers' pneumoconiosis. Furthermore, Drs. Fino, Jarboe, Castle, Zaldivar, Dahhan and Spagnolo are all B-readers and board-certified in internal medicine and pulmonary diseases. All of these qualified physicians unanimously found that the X-rays taken shortly before Mr. Collins' death showed no evidence of pneumoconiosis.

> (5) In the absence of contrary probative evidence, the adjudication officer shall accept the statement of a physician with regard to the factors listed in paragraphs (d)(1) through (4) of this section. In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole.

In its comments to the amended regulations, the Department states the following:

> The Department emphasizes that the 'treating physician' rule guides the adjudicator in determining whether the physician's doctor-patient relationship warrants special consideration of the doctor's conclusions. The rule does not require the adjudicator to defer to those conclusions regardless of the other evidence in the record. The adjudicator must have the latitude to determine which, among the conflicting opinions, presents the most comprehensive and credible assessment of the miner's pulmonary health. For the same reasons, the Department does not consider subsection (d) to be an evidentiary presumption which shifts the burden of production or persuasion to the party opposing entitlement upon the submission of an opinion from the miner's treating physician. Accordingly, the Department declines to eliminate the requirement in subsection (d)(5) that a treating physician's opinion must be considered in light of all relevant evidence in the record.

Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, 65 Fed. Reg. 79,334 (Dec. 20, 2000).

In addition, while all of these physicians noted that Mr. Collins suffered from chronic obstructive pulmonary disease, they asserted his respiratory impairment was the result of his extensive smoking history and not the result of coal mine dust exposure. More specifically, Drs. Castle and Spagnolo both found that Mr. Collins' elevated PaCo2 levels are more consistent with a smoking related respiratory impairment. Additionally, Dr. Fino added that Mr. Collins's obstructive abnormality occurred in the absence of any interstitial abnormality, which he opined indicates that Mr. Collins' chronic obstructive pulmonary disease was secondary to smoking. Furthermore, as stated above, Mr. Collins' treating physician, Dr. Younes, did not address the effect of Mr. Collins' smoking history on his respiratory condition, and therefore, Dr. Younes did not effectively rule out a diagnosis of smoking induced chronic obstructive pulmonary disease.

Accordingly, I find that claimant has failed to show, by a preponderance of the evidence, that Mr. Collins had coal workers' pneumoconiosis as required by the Act and Regulations.

D. Cause of pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

Since the parties have stipulated that Mr. Collins had eleven years of coal mine employment, the claimant would ordinarily receive the benefit of the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. However, in view of my finding that the existence of pneumoconiosis has not been proven this issue is moot.

E. Death due to Pneumoconiosis

Subsection 718.205(c) applies to survivor's claims filed on or after January 1, 1982 and provides that death will be due to pneumoconiosis if any of the following criteria are met:

> (1) competent medical evidence established that the miner's death was due to pneumoconiosis; or
>
> (2) pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or the death was caused by complications of pneumoconiosis; or
>
> (3) the presumption of § 718.304 [complicated pneumoconiosis] is applicable.

The Board concludes that death must be "significantly" related to or aggravated by pneumoconiosis, while the circuit courts have developed the "hastening death" standard which requires establishment of a lesser causal nexus between pneumoconiosis and the miner's death. *Foreman v. Peabody Coal Co.*, 8 B.L.R. 1-371, 1-374 (1985). The United States Court of Appeals for the Third Circuit has held that any condition that *hastens* the miner's death is a substantially contributing cause of death for purposes of § 718.205. *Lukosevicz v. Director, OWCP*, 888 F.2d 1001 (3d Cir. 1989). The Fourth Circuit has adopted this position in *Shuff v. Cedar Coal Co.*, 967 F.2d 977 (4th Cir. 1992), *cert. den.* 506 U.S.1050, 113 S.Ct. 969 (1993).

Survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death. 20 C.F.R. § 718.205(c)(4). *Neeley v. Director, OWCP*, 11 B.L.R. 1-85 (1988) (survivor not entitled to benefits where the miner's death was due to a ruptured abdominal aortic aneurysm).

The Act and Regulations do not require that pneumoconiosis be the sole, primary or proximate cause of death, but rather that where the principal cause of the miner's death was not pneumoconiosis, that the evidence establish it was a "substantially contributing cause." 20 C.F.R. § 718.205(c)(4). *See, Lukosevicz v. Director, OWCP*, 888 F.2d 1001, 1005 (3rd Cir. 1989)(quoting 48 Fed. Reg. 24,276, 24,277(1), (n)(1983)). In *Richardson v. Director, OWCP*, 94 F.3d 164, 167 (4th Cir. 1996), the Fourth Circuit Court of Appeals stated that, in a survivor's claim under Part 718, Claimant must demonstrate that pneumoconiosis "hastened" the miner's death "in any way."

Since I have found that the evidence of record fails to establish, by a preponderance of the evidence that Mr. Collins had coal worker's pneumoconiosis, I accordingly find that there is insufficient evidence establishing that pneumoconiosis was a substantially contributing cause of Mr.Collins' death.

E. Attorney fees

The award of attorney's fees, under the Act, is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for the representation services rendered to him in pursuit of the claim.

CONCLUSIONS

In conclusion, the claimant, Nora Collins, has failed to demonstrate, by a preponderance of the evidence, that the decedent-miner, Johnnie J. Collins, had pneumoconiosis, as defined by the Act and Regulations at the time of his death. Accordingly, claimant has additionally failed to show that pneumoconiosis was a substantially contributing cause or factor leading to the decedent-miner's death. The claimant is therefore not entitled to benefits.

ORDER

It is ordered that the claim of Nora Collins for survivor benefits under the Black Lung Benefits Act is hereby DENIED.

A
RICHARD A. MORGAN
Administrative Law Judge

RAM:ALS:dmr

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits review Board within 30 days from the date of this Order by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601**. A copy of a Notice of Appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, at the Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Appendix A

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifi c-ations	Film Quality	ILO Class-ification	Interpretation or Impression
EX 3	2/27/85 10/17/98	Wheeler	B, BCR	2	__	normal except subtle left apical pleural thickening
EX 3	2/27/85 10/16/98	Scott	B, BCR	2	__	
EX 4	2/27/85 10/20/98	Kim	B, BCR	2	__	possible apical pleural thickening
EX 7	2/27/85 12/15/98	Morgan	B	1	__	normal radiograph
EX 13	2/27/85 1/3/00	Hippensteel	B	1	__	
EX 13	2/27/85 1/4/00	Castle	B	1	0/1 q, rl	
EX 5	8/7/97 10/21/98	Spitz	B, BCR	UR		
EX 13	8/7/97 1/3/00	Hippensteel	B	3	__	pulmonary vascular congestion, mild CHF
EX 13	8/7/97 1/4/00	Castle	B	3	__	changes of CHF
EX 12	8/7/97 11/22/99	Fino	B	1	__	cardiomegaly and congestive heart failure present
EX 5	9/6/97 10/21/98	Spitz	B, BCR	2	__	
EX 2	9/6/97 11/22/99	Fino	B	3	__	cardiomegaly and congestive heart failure present
EX 13	9/6/97 1/3/00	Hippensteel	B	3	__	mild CHF
EX 13	9/6/97 1/4/00	Castle	B	3	__	

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifi c-ations	Film Quality	ILO Class-ification	Interpretation or Impression
EX 5	9/7/97 10/21/98	Spitz	B, BCR	2	__	
EX 7	9/7/97 12/5/98	Morgan	B	3	__	
EX 12	9/7/97 11/22/99	Fino	B	3	__	cardiomegaly and congestive heart failure present
EX 13	9/7/97 1/3/00	Hippensteel	B	3	__	CHF
EX 13	9/7/97 1/4/00	Castle	B	3	__	
EX 12	9/10/97 11/22/99	Fino	B	3	__	cardiomegaly and congestive heart failure present
EX 5	9/10/97 10/21/98	Spitz	B, BCR	2	__	borderline cardiomegaly
EX 13	9/10/97 1/3/00	Hippensteel	B	3	__	CHF
EX 13	9/10/97 1/4/00	Castle	B	3	__	CHF, early pulmonary edema

* A- A-reader; B- B-reader; BCR- Board-certified radiologist; BCP-Board-certified pulmonologist; BCI= Board-certified internal medicine. Readers who are Board-certified radiologists and/ or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 N.16, 98 L.Ed. 2d 450 (1987) and, *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B-readers need not be radiologists.

** The existence of pneumoconiosis may be established by chest X-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest X-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp.*, 6 B.L.R. 1-307 (1983)(Under Part 727 of the Regulations) and *Billings v. Harlan #4 Coal Co.*, BRB No. 94-3721 (June 19, 1997))*(en banc*)(*Unpublished*). If no categories are chosen, in box 2B(c) of the X-ray form, then the x-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.